CENTERIO I OF	MEDICANE & MEDIC					0.11	18 110:00000
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC	00	COMPI	LETED
		155376	A. BUII		-	09/16/2	2011
			B. WIN				
NAME OF P	ROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
				803 S	HAMILTON STREET		
SHERIDA	AN REHABILITATIO	ON AND HEALTHCARE CENTER		SHER	IDAN, IN46069		
(V4) ID	CLIMMA DV	STATEMENT OF DEFICIENCIES	_	ID	1		(V5)
(X4) ID					PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG DEFICIENCY)		DEFICIENCY)		DATE
F0000							
	This visit was fo	or a Recertification and	F0	000	Preparation or execution of the	his	1
			"		plan of		
	State Licensure	survey.			Correction does not constitut	e an	
					admission or assent by the		
	Survey dates: S	eptember 12, 13, 14, 15,			provider to the truth, accurac	ev or	
	and 16, 2011	•			veracity of the facts alleged o	-	
	una 10, 2011				conclusions set forth in the	•	
					statement of deficiencies. Th	e nlan	
	Facility number:	: 000336			of correction is prepared and		
	Provider number	r: 155376			executed solely because it is		
	AIM number: 1	00290170			•		
	7 thvi number. 1	00270170			required under law.		
					D 41: 61 :1		
	Survey team:		By this response, Sheridan				
	Janet Stanton, R	NTeam Coordinator			Rehabilitation and Healthcar		
	Rita Mullen, R.N				Center acknowledges receipt	of the	
	,				statement of deficiencies and		
	Heather Lay, R.	N. (9/12, 13, 14, 15)			alleges that it is in compliance	e as of	
	Michelle Hostet	er, R.N. (9/13, 14, 15)			10/11/11		
	Census bed type	•			Sheridan Rehabilitation and		
	• •	•			Healthcare Center reserves th		
	SNF/NF76				right to submit documentatio		
	Total76				refute any of the stated defici	encies	
					on this statement of deficienc	ies	
	Census payor ty	ne·			through informal dispute		
	Medicare6	r - ·			resolution, formal appeal and		
					any other administrative or le	egal	
	Medicaid55				proceeding		
	Other15						
	Total76				This plan of correction does n	ot	
					constitute		
					Admission or agreement by t		
	Sample: 16				provider of the truth of the fa	icts	
					alleged or conclusions set for	th in	
	These deficiencies reflect State findings				this statement of deficiencies.	This	
			I I		plan of correction is prepared		
	cited in accordance with 410 IAC 16.2.		solely because it is required by				
					Law.	•	
	Quality review completed 9/21/11						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HEBU11

Facility ID:

000336

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376		(X2) MU A. BUII B. WIN	DING	NSTRUCTION  00	(X3) DATE ( COMPL <b>09/16/2</b>	ETED	
	PROVIDER OR SUPPLIER  AN REHABILITATIO	N AND HEALTHCARE CENTER	р. WIW	STREET A	DDRESS, CITY, STATE, ZIP CODE HAMILTON STREET DAN, IN46069		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) RN		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
F0242 SS=D	schedules, and he or her interests, as care; interact with both inside and out choices about asp facility that are sig Based on record facility failed to perfect the choices in regard deficient practice resident's review in a sample of 16 [Resident #14]  Findings include  The clinical record reviewed on 9/14 resident was admidiagnoses which limited to, end-st dialysis, depression non-insulin dependent of the control of the choices in the control of the	rd for Resident #14 was 1/11 at 2:00 P.M. The 1/1tted on 8/19/11 with 1/10 included, but were not age renal disease, renal ve disorder, and	F0	242	F242 Self Determination-Rig to make Choices 1. Residen #14 was discharged from the facility on 09/19/11. 2. All residents with an order for fluorestriction were identified. The dietary manager completed a Resident Preference Review including preference of divisional fluids for all identified resident See Attachment #1 3. All residents admitted with or obtaining a new order for fluir restriction will have a Reside Preference Review including preference of division of fluid completed by the dietary manager or designee within a hours and then quarterly. An in-service on resident rights we completed on 9/30/11. See Attachment #2 4. Medicals Records or designee will more that Resident Preference Reviews including preference division of fluids were completed on admission audit and for neadmits upon data entry for neadmits	it id e id id id e id	10/11/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155376	B. WIN			09/16/2	011
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				HAMILTON STREET		
SHERIDA	AN REHABILITATIO	N AND HEALTHCARE CENTER		1	DAN, IN46069		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
		tion] sheet included, but			assurance meetings. See		
	were not limited	to, "1500 milliliters [ml]			Attachment #3 Dietary Manger Responsible Medical Records to		
	fluid restriction - 340 ml each meal, 120 ml each medication pass"				monitor Date of completion: 10/11/11		
	There was one C	are Plan entry titled					
		nce," dated 8/22/11. The					
		e listed as: "1500 fluid					
	restriction; labs p						
	In an interview o	on 9/15/11 at 12:45 P.M.,					
		ted Resident #14 was on					
		of 1500 ml. daily. She					
		d not keep track of the					
		•					
		unt consumed by the					
		nour period. The nurse					
		ident's dialysis agency					
		daily fluid intake "by					
	· ·	nt was taken off [fluid					
		hemodialysis]" on					
	•	P.N. #6 indicated there					
	was no record of	Resident #14's actual					
	fluid intake.						
	On 9/15/11 at 1:0	00 P.M., the Director of					
	Nursing [DoN] p	provided a					
	Policy/Procedure	e titled "Clinical					
	Programs Manua	ıl: Hydration" with					
	revised date of 8	/10. The document					
	included, but was	s not limited to, the					
	following: "Proc	cedure: Implement					
	individualized in	terventions based on					
	resident/patient r	needs and goals, which					
	_	ake to maintain sufficient					
					<u> </u>		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S COMPL		
		155376	B. WIN			09/16/2	011
	PROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER	·!	803 S	DDRESS, CITY, STATE, ZIP CODE HAMILTON STREET DAN, IN46069		
	AN REHABILITATIO  SUMMARY S' (EACH DEFICIENCE REGULATORY OR Provided in the fact not asked what fle drink, or how he divided throughour reason, Resident finished his drink because he knew drinking a lot because he knew drinking a lot because he did were divided for medication passes  On 9/15/11 at 2:2 titled "Nutrition South Nutrition Practice with review date the Assistant Direct [ADoN]. The downs not limited to Services and Nutrition Summary of the Assistant Direct Canada Services and Nutrition Summary of the Summary of t	N AND HEALTHCARE CENTER  TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  In 9/15/11 at 1:20 P.M., his wife indicated they whis fluid restriction cility. The resident was uids he preferred to would like his fluids ut the day. For this #14 indicated he never as on his meal trays he should not be cause of his kidney at #14's wife also not realize his fluids meal trays and s.  20 P.M., a document Services Manual: e: Fluid Maintenance" of 6/09 was provided by ector of Nursing cument included, but		803 S	HAMILTON STREET	TE	(XS) COMPLETION DATE
		dent/patient on fluid					

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, ,,,,,,	DDIG	00	COMPL	ETED
		155376	A. BUIL B. WING			09/16/2	011
			D. WINC	_	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				HAMILTON STREET		
SHERIDA	AN REHABILITATIO	N AND HEALTHCARE CENTER			)AN, IN46069		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
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TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0278 SS=D	The assessment must accurately reflect the resident's status.						
	A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that						
	the assessment is	completed.					
	Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.						
	Clinical disagreem material and false	nent does not constitute a statement.					
	interview, the fac	review, observation, and cility failed to document a	F02	278	F-278 Assessment Accuracy/Coordination/Certif	ied	10/11/2011
	resident's relevant care areas accurately and correctly within the "Minimum Data Set" [M.D.S.] assessment. This deficient practice impacted 1 of 16 residents reviewed. [Resident #39]  Findings included:				1. Modification of closed MDS, assessment date of 6/7/11, was completed on 9/12/11 and subm on 9/13/11 for resident #39. See attachment #4 2. All residents have the potenti be affected by the same deficier practice. The MDS Coordinato designee will compare the	nitted al to	
		9:15 A.M., tour was Director of Nursing			documented score on relevant c areas on last submitted MDS to		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HEBU11 Facility ID:

000336

If continuation sheet

Page 5 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155376 09/16/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 803 S HAMILTON STREET SHERIDAN REHABILITATION AND HEALTHCARE CENTER SHERIDAN, IN46069 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE [DoN]. During interview at that time, the Care Tracker One Click MDS 3.0 Report. Any areas of DoN indicated that Resident #39 Noted discrepancy will be reviewed ambulated without assistance in the and corrected as indicated. See hallways. Resident #39 was observed to attachment #5 be walking without difficulty, and without 3. Documented scores on relevant assistance, in the hallways of the facility. care areas on all MDS assessments will be compared to the Care Tracker One Click MDS 3.0 Report. Any On 9-13-2011 at 10:00 A.M., Resident areas of noted discrepancy will be #39's record was reviewed. Diagnoses reviewed and corrected as indicated included, but were not limited to, prior to submission. A copy of the Care Tracker One Click MDS 3.0 dementia with behavior disturbances and Report will then be attached to the hypothyroidism. MDS. An in-service on relevant care area MDS documentation will be Resident #39's "Minimum Data Set completed on 10/3/11 and 10/10/11. Version 3.0" [M.D.S.] with "Assessment See attachment #6 MDS Responsible DON to monitor reference date" of 3-8-2011 and "Type of 4. Date of completion 10/11/11 assessment: Annual" included, but was not limited to, Functional Status, Bed Mobility: self performance: Independent - no help or staff oversight at any time, Transfer: self performance: Independent - no help or staff oversight at any time..." Resident #39's "Minimum Data Set -Version 3.0" [M.D.S.] with "Assessment reference date" of 6-7-2011 and "Type of assessment: Quarterly" included, but was not limited to, Functional Status, Bed Mobility: self performance: Total dependence - full staff performance every time during entire 7-day period, Transfer: self performance: Extensive assistance resident involved in activity, staff provide weight-bearing support..."

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376		A. BUI	LDING	ONSTRUCTION 00	(X3) DATE S COMPL 09/16/20	ETED	
		155576	B. WIN		DDDDGG GITH GTATE ZID GODE	09/10/20	
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE HAMILTON STREET		
SHERIDA	AN REHABILITATIO	N AND HEALTHCARE CENTER		1	DAN, IN46069		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	Nurse's notes [Pr 5-29-2011 at 3:00 Resident #39 was hallways.  Social Service [P 6-1-2011, no time attended the "Ass was up ad lib was meeting"  On 9-14-2011 at Data Set [M.D.S. Registered Nurse The M.D.S. Coor Resident #39's as was incorrectly e L.P.N. # 5 and "S Status" was incorrected M.D.S. assessment refered The corrected very Resident #39 was was incorrected was sessible to the corrected very resident #39 was the corrected very resident #39 was was incorrected was sessible to the corrected very resident #39 was was was incorrected very resident #39 was was a sessible to the corrected very resident #39 was was was a sessible to the corrected very resident #39 was was a sessible to the corrected very resident #39 was was a sessible to the corrected very resident #39 was a sessible to the corrected w	ogress Notes] dated O P.M., indicated s up ambulating in the  rogress Notes] dated e, indicated Resident #39 sessment Meeting" and indering in and out of		TAG			DATE
F0327 SS=D		rovide each resident with ke to maintain proper lth.					

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155376	B. WIN			09/16/2	011
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NAME OF P	PROVIDER OR SUPPLIEF	8			HAMILTON STREET		
SHERIDA	AN REHARII ITATIC	ON AND HEALTHCARE CENTER			DAN, IN46069		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREFIX				COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG				DATE
	Based on record review and interview, the		F0	327	F-327 SUFFICIENT FLUID T	O	10/11/2011
	facility failed to follow facility guidelines in regard to fluid intake monitoring. This				MAINTAIN HYDRATION 1. Resident #14 was discharged	4	
					from the facility on 9/19/11. 2		
	deficient practice	e impacted 1 of 2			residents with an order for a		
	resident's review	red on a fluid restriction			intake monitoring were being		
		6 residents reviewed.			followed. Attachment #7 3.		
	[Resident #14]	z z z z z z z z z z z z z z z z z z z			Medical Records or designed		
	[Resident #14]				monitor all residents admitted		
	D: 1: : 1 1				with or obtaining a new order		
	Findings include	: :			a fluid restriction to ensure th		
					facility guidelines in regard to intake monitoring is being	iluid	
	The clinical record for Resident #14 was				followed on admission audit	for	
	reviewed on 9/14	4/11 at 2:00 P.M. The			new admits upon data entry	-	
	resident was adn	nitted on 8/19/11 with			intake and output monitoring		
	diagnoses which	included, but were not			be held on 10/3/11 and 10/10	0/11	
	_	tage renal disease, renal			Attachment #8 4. Medical		
	dialysis, depress	•			Records or designee will mo		
					all residents admitted with or		
	non-insulin depe	endent diabetes.			obtaining a new order for a fl restriction to ensure that facil		
					guidelines in regard to fluid in	•	
		M.D.S. [Minimum Data			monitoring is being complete		
	Set] assessment,	dated 8/26/11, indicated			admission audits and data er		
	the resident had	a BIMS [Brief Interview			for new orders one existing		
	for Mental Status	s] score of 11, which			residents. Concerns will be		
	represented "mo	derately impaired"			submitted in monthly quality		
	cognitive status.	J 1			assurance meeting on all		
	cognitive status.				residents on fluid restriction.  Medical Records responsible		
	The Santambar 1	2011 physician order			Quality Assurance to Monitor		
	•	* *			Date of completion 10/11/11		
		tion] sheet included, but			Addendum: 3. Medical Reco	ords	
	were not limited to, "1500 milliliters [ml]				is an LPN. Designee will be		
	fluid restriction - 340 ml each meal, 120				nurse on duty. Monitoring wil	l be	
	ml each medication pass"  Physician's orders for 9/2011 included,				done weekly by the		
					LPN. Communication to	/00	
					caregivers will be done daily, needed on the Caretracker.		
	-	ited to, "1500 ml fluid			Medical Records who is an L		
		ml each meal, 120 ml			will report to the QA		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155376	B. WIN	G		09/16/2	U11
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	HAMILTON STREET		
SHERIDA	AN REHABILITATIO	N AND HEALTHCARE CENTER		SHERI	DAN, IN46069		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	each medication	pass"			CommitteeMonthly/Quarterly	/.	
		nance" care plan dated					
	8-22-2011, indicate	ated "Approach: 1500					
	fluid restriction v	•					
	department respo	onsible for approach."					
		n 9/15/11 at 12:45 P.M.,					
	L.P.N. #6 indicat	ted Resident #14 was on					
	a fluid restriction	of 1500 ml. daily. She					
	indicated staff di	d not keep track of the					
	actual fluid amou	ant consumed by the					
	resident in a 24 h	our period. The nurse					
	indicated the resi	dent's dialysis agency					
		daily fluid intake "by					
	•	it was taken off [fluid					
	_	hemodialysis]" on					
	_	P.N. #6 indicated there					
		Resident #14's actual					
	fluid intake.	resident #115 detaal					
	nuia intake.						
	   On 9/15/11 at 1:0	00 P.M., the Director of					
	Nursing [DoN] p						
	Policy/Procedure						
		l: Hydration" with					
	_	/10. The document					
	*	s not limited to, the					
	-	cedure: Implement					
		terventions based on					
	-	needs and goals, which					
	•	ake to maintain sufficient					
	hydration"						
	In an interview o	n 9/15/11 at 1:20 P.M.,					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155376		(X2) MUI A. BUILD B. WING		00	(X3) DATE S COMPL 09/16/2	ETED	
	PROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		803 S H	DDRESS, CITY, STATE, ZIP CODE HAMILTON STREET AN, IN46069		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	did not know how worked in the fact not asked what for drink, or how he divided throughed reason, Resident finished his drink because he knew drinking a lot bedisease. Resider indicated she did were divided for medication passes.  On 9/15/11 at 2.22 titled "Nutrition Nutrition Practice with review date the Assistant Dir [ADoN]. The downs not limited to Services and Nutritor managing the	not realize his fluids meal trays and es.  20 P.M., a document Services Manual: e: Fluid Maintenance" of 6/09 was provided by					

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, рин	DING	00	COMPL	ETED
		155376	A. BUILDING B. WING  09/16/2011				011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				HAMILTON STREET		
SHERIDA	AN REHABILITATIO	N AND HEALTHCARE CENTER		l	DAN, IN46069		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORR		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0371 SS=F	The facility must - (1) Procure food from some considered satisfal local authorities; a (2) Store, prepare, under sanitary combased on observation facility failed to a sanitary condition to affect 76 of 76 food from 1 of 1.  Findings include:  During the initial A.M., the meat shour covered.  During the kitcher A.M., the meat shour food storage observed to be claim interview at the manager indicate only used a few the not indicate the later the Dietary Manager occessor was us	rom sources approved or ctory by Federal, State or nd distribute and serve food additions action and interview, the store a meat slicer in a n. This had the potential of residents who are served kitchens.	F0	371	F-371 Food Procure, Store, Prepare, Serve-sanitary  1. The meat slicer was cleaned covered by the dietary manage 9/13/11. 2. The Safety and Sanitation Rewas completed by the Administ on 9/16/11 to ensure that all equipment was stored in a sanit condition. See Attachment #9 3. The Safety and Sanitation Rewas modified to include the san storage of meat slicer. The administrator or designee will continue to complete this review weekly. The dietician will continue to complete a Sanitation Audit quarterly. See Attachment #10 in-service on sanitary equipmer storage will be held on 10/3/11 10/10/11. 4. Weekly Safety and Sanitation Review and quarterly dietician Sanitation Audits will e submitt the monthly quality assurance meeting. Dietary Manager responsible Administrator and Dietician to monitor Completion date: 10/11/11	on eview rator ary eview itary  V inue An at and	10/11/2011

IDENTIFICATION NUMBER: 155376  INVINO  ISSUM REHABILITATION AND HEALTHCARE CENTER  SHERIDAN IN46069  IDENTIFICATION REPORTED BY PILIT.  PREFIX  GEACH DEPTICISKY MIST BE PERCEDED BY PILIT.  PREFIX  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessable, and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments, the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  A. Based on record review and interview, the facility failed to document the specific interventions used to redirect a resident with disruptive behaviors. This impacted 1 of 9 residents reviewed for behaviors in a sample of 16. (Resident #16)  B. Based on record review and interview, the facility failed to follow facility guidelines in regard to fluid intake documentation. This deficient practice impacted 1 of 2 residents reviewed on a fluid restriction in a sample of 16 residents reviewed. [Resident #16]  Findings include:  A.1. The clinical record of Resident #16 included, but were not limited to, depression, paranoid schizophrenia and dementia. A quarterly behavior of administration in administration in a discounter and dementia. A quarterly behavior of administration in administration in a discounter and dementia. A quarterly behavior is proint administration.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER  NERPIX TAG  SIMMARY STATIMENT OF DETICENCIES  REGISTATORY OR INCIDENTIFYING PROMATION)  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the residents assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  A. Based on record review and interview, the facility failed to document the specific interventions used to redirect a resident with disruptive behaviors. This impacted 1 of 9 residents reviewed for heaviers in a sample of 16. (Resident #16)  B. Based on record review and interview, the facility failed to follow facility guidelines in regard to fluid intake documentation. This deficient practice impacted 1 of 2 resident's reviewed on a fluid restriction in a sample of 16 residents reviewed. [Resident #14]  Findings include:  A.1. The clinical record of Resident #16 was reviewed on 9/14/11 at 2:00 P.M.  Diagnoses for Resident #16 included, but were not limited to, depression, paranoid sehizonephrania and dementia. A quarterly were reviewed to resident discontinuous used to redirected residents with disruptive residents with disruptive residents and complete accurate. All residents with a fluid restriction were identified and reviewed to ensure facility guidelines on fluid intake document on the back of Medication Administration Record all specific interventions used to redirected residents with a fluid restriction were identified and reviewed to ensure facility guidelines on fluid intake were being followed. 3. Licensed Nurses are to document on the back of Medication Administration Record all specific interventions used to redirected residents with disruptive	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	DING	00	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER  SHERIDAN, IN46069  SUMMARY STREMENT OF DERICISCITS  (EACH DEFICIENCY MUST BE PERCEDED BY PULL REGILATOR STREET)  TAG  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the result of any preadmission screening conducted by the State; and progress notes.  A. Based on record review and interview, the facility failed to document the specific interventions used to redirect a resident with disruptive behaviors. This impacted I of 9 residents reviewed for behaviors in a sample of 16. (Resident #16)  B. Based on record review and interview, the facility failed to follow facility guidelines in regard to fluid intake documentation. This deficient practice impacted I of 2 resident's reviewed on a fluid restriction in a sample of 16 residents reviewed. [Resident #14]  Findings include:  A.1. The clinical record of Resident #16 was reviewed on 9/14/11 at 2:00 P.M.  Diagnoses for Resident #16 included, but were not limited to, depression, paranoid sehizonderous and dementia, A quarterly were reviewed in dispersion for residents with disruptive provision and provision and provision resident for resident with disruptive provision record of resident profile for residents with a fluid restriction were identified and reviewed to ensure facility guidelines on fluid intake were being followed. 3. Licensed Nurses are to document on the back of Medicalion Administration Record all specific interventions used to redirected residents with disruptive were reviewed to residents with disruptive provisions.			155376	1		<del></del>	09/16/2	011
SHERIDAN REHABILITATION AND HEALTHCARE CENTER  IXA ID  IXA ID  IXA IMANAY STATEMENT OF DEBICINCIES  PREFIX TAG  REGULATORY OR LOC IDENTIFYING INFORMATION)  TAG  TO REGULATORY OR LOC IDENTIFYING INFORMATION)  TAG  TO REGULATORY OR LOC IDENTIFYING INFORMATION)  TAG  TO REGULATORY OR LOC IDENTIFYING INFORMATION)  TAG  The delinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  A. Based on record review and interview, the facility failed to document the specific interventions used to redirect a resident with disruptive behaviors. This impacted 1 of 9 residents reviewed for behaviors in a sample of 16. (Resident #16)  B. Based on record review and interview, the facility failed to follow facility guidelines in regard to fluid intake documentation. This deficient practice impacted 1 of 2 resident's reviewed on a fluid restriction in a sample of 16 residents reviewed. [Resident #14]  Findings include:  A.1. The clinical record of Resident #16 was reviewed on 9/14/11 at 2:00 P.M.  Diagnoses for Resident #16 included, but were not limited to, depression, paranoid existing the procession of the previous subtractions and continues until disparage on 9/14/11 at 2:00 P.M.  Diagnoses for Resident #16 included, but were not limited to, depression, paranoid existing the paramodal continues and precision of the previous previous previous previous previous previous previous and dementia. A quarterly to the provious previous previous previous previous previous previous previous subtractions and continues and provious previous				p. White		DDRESS CITY STATE ZIP CODE		
SHERIDAN, IN46069  IXAI D  SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MIST BE PERCEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  A. Based on record review and interview, the facility failed to document the specific interventions used to redirect a resident with disruptive behaviors. This impacted 1 of 9 residents reviewed for behaviors in a sample of 16. (Resident #16)  B. Based on record review and interview, the facility failed to follow facility guidelines in regard to fluid intake documentation. This deficient practice impacted 1 of 2 residents reviewed on a fluid restriction in a sample of 16 residents reviewed. [Resident #14]  Findings include:  A.1. The clinical record of Resident #16 was reviewed on 9/14/11 at 2:00 P.M.  Diagnoses for Resident #16 included, but were not limited to, depression, paranoid existions and dementia. A quarterly with a contract of the provision of the provision with a quarterly by the provision of the provision of the provision with a specific interventions were accurate. All residents with a fluid restriction on Administration Record all specific interventions used to redirected residents with disruptive	NAME OF P	ROVIDER OR SUPPLIER						
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  A. Based on record review and interview, the facility failed to document the specific interventions used to redirect a resident with disruptive behaviors. This impacted 1 of 9 residents reviewed for behaviors in a sample of 16. (Resident #16)  B. Based on record review and interview, the facility failed to follow facility guidelines in regard to fluid intake documentation. This deficient practice impacted 1 of 2 resident's reviewed on a fluid restriction in a sample of 16 residents reviewed. [Resident #14]  Findings include:  A.1. The clinical record of Resident #16 was reviewed on 9/14/11 at 2:00 P.M.  Diagnoses for Resident #16 included, but were not limited to, depression, paranoid schizophrenia and dementia. A quarterly were lossed and the part of the residents with disruptive	SHERIDA	AN REHABILITATIO	N AND HEALTHCARE CENTER					
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION THE facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the residents assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  A. Based on record review and interview, the facility failed to document the specific interventions used to redirect a resident with disruptive behaviors. This impacted 1 of 9 residents reviewed for behaviors in a sample of 16. (Resident #16)  B. Based on record review and interview, the facility failed to follow facility guidelines in regard to fluid intake documentation. This deficient practice impacted 1 of 2 resident's reviewed on a fluid restriction in a sample of 16 residents reviewed. [Resident #14]  Findings include:  A.1. The clinical record of Resident #16 was reviewed on 9/14/11 at 2:00 P.M.  Diagnoses for Resident #16 included, but were not limited to, depression, paranoid eshizophrenia and dementia. A quarterly were lost of the residents with disruptive.	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	PROVIDER'S PLAN OF CORRECTION			(X5)	
F0514 SS=D  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  A. Based on record review and interview, the facility failed to document the specific interventions used to redirect a resident with disruptive behaviors. This impacted 1 of 9 residents reviewed for behaviors in a sample of 16. (Resident #16)  B. Based on record review and interview, the facility failed to follow facility guidelines in regard to fluid intake documentation. This deficient practice impacted 1 of 2 resident's reviewed on a fluid restriction in a sample of 16 residents reviewed. [Resident #14]  Findings include:  A.1. The clinical record of Resident #16 was reviewed on 9/14/11 at 2:00 P.M.  Diagnoses for Resident #16 included, but were not limited to, depression, paranoid schizophrenia and dementia. A quanterly were not limited to, depression, paranoid schizophrenia and dementia. A quanterly were sold interventions used to redirected residents with situptive	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	I	CROSS-REFERENCED TO THE APPROPRIATE		E	COMPLETION
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behaviors prior to administration	F0514 SS=D	each resident in approfessional stand complete; accurate accessible; and sy.  The clinical record information to identhe resident's asseand services provipreadmission screeces. A. Based on record the facility failed interventions use with disruptive by 1 of 9 residents reasonable as a sample of 16.  B. Based on record the facility failed guidelines in regided guidelines in regided cumentation. Impacted 1 of 2 refluid restriction is residents reviewed.  Findings include  A.1. The clinical was reviewed on Diagnoses for Regider and Standard Regider.	coordance with accepted lards and practices that are ely documented; readily estematically organized.  I must contain sufficient nitify the resident; a record of essments; the plan of care ided; the results of any sening conducted by the senotes.  Ford review and interview, I to document the specific ed to redirect a resident sehaviors. This impacted eviewed for behaviors in (Resident #16)  Ford review and interview, I to follow facility and to fluid intake. This deficient practice resident's reviewed on a man a sample of 16 ed. [Resident #14]  I record of Resident #16  9/14/11 at 2:00 P.M.  Resident #16 included, but to, depression, paranoid	F05	514	Complete/Accurate/Accessi 1. The Behavior Detail Report Care Plan, MAR and Care Tracker Resident Profile for Resident #16 were reviewed ensure that specific intervent were complete, accurate. Re accessible, and systematical organized. An intake record initiated on 9/15/11 for reside #14 and continues until disch on 9/19/11. 2. The Behavior I Report, Care Plan, Mar and of Tracker Resident Profile were reviewed for any resident wit behavioral symptoms in the I 30 days to ensure that specif interventions were accurate. residents with a fluid restriction were identified and reviewed ensure facility guidelines on the intake were being followed. 3 Licensed Nurses are to docu on the back of Medication Administration Record all specinterventions used to redirect residents with disruptive	to ions adily ly was ent aarge Detail care e h ast fic All on to fluid B. ment	10/11/2011
		schizophiema an	u ucincinia. A quarterry			behaviors prior to administrate	tion	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	DING	00	COMPL	ETED
		155376	A. BUII B. WIN			09/16/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8					
OLIEDID.	***				HAMILTON STREET		
SHERID	AN REHABILITATIC	ON AND HEALTHCARE CENTER		SHERIL	DAN, IN46069		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL					COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)					DATE
	Minimum Data Set Assessment, dated				of PFRN psychopharmologic		
	4/19/11, indicated Resident #16 wandered and had severely impaired decision making skills.				medications. Medical Recor		
					designee will monitor all resi		
					admitted with or obtaining an		
					order for fluid restrictions or I		
					medications. An in-service or	n	
	A review of the	September, 2011			documentation Of specific behavioral interventions and	fluid	
	Physician Order	Summary indicated			intake will be held 10/311 and		
	Resident #16 had	d an order for Haloperidal			10/10/11 See attachment #1		
		sychotic medication] 1			Medical Records or designed		
		-			review medication administra		
		P.O. [by mouth] or I.M.			records in daily care review t	o	
	I -	njection] every 4 hours			identify any resident whom		
	P.R.N. [as neede	ed] for agitation,			received a prn		
	aggression.				psychophamalogical medical		
					to ensure specific interventio	ns	
	The August 201	1 M.A.R. [Medication			were documented. Medical		
	1	Record] indicated			Records or designee will revi		
		_			intake records on all resident		
		eived Haloperidal 1 mg.			a fluid restriction in daily care review to ensure fluid intake		
	1	ion/aggression on the			documented. Concerns will		
	following dates:	8/6/11, 8/15/11, 8/17/11			submitted in the monthly QA		
	and 8/19/11.				meeting. Licensed Nursing S	Staff	
					Responsible, Medical Record		
	A behavior moni	toring "Behavior Detail			monitor Date of completion		
		_			10/11/11 Addendum: 3. Med	ical	
		d from the Assistant			Records is an LPN. Designe		
		ing on 9/16/11 at 9:05			be the nurse on duty. Monito	-	
	A.M., indicated	Resident #16 had the			will be done daily/weekly by	the	
	following behav	iors:			LPN. Communication to	,	
					caregivers will be done daily		
	8/6/11 at 8:00 P	M.: "Resident #16 was			needed on the Caretracker. 4 Licensed Nursing Staff	+.	
					Responsible. Medical Record	1e	
	physically abusive to staff. The behavior was not easily altered by diversion activities, redirection or toileting." Other than "toileting", there was no indication				who is an LPN will report to t		
					QA CommitteeMonthly/Quart		
	what specific int	erventions were used for					
	_	ties," or ""redirection,"					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376			(X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING  (X3) DATE SURVE COMPLETED 09/16/2011			ETED		
NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  803 S HAMILTON STREET					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	1 ^	prior to the resident receiving the Haloperidal as an intervention.						
	was screaming, of and disruptive. It is a series as a series in the respectific intervention receiving Halopo was screaming, of staff. The behave by validation or indication what is were used for "v	A.M.: "Resident #16 causing excessive noise The behavior was not 1:1 [one-to-one] or was no indication what tions were used for the a," prior to the resident eridal as an intervention.  A.M.: "Resident #16 cursing and hitting at rior was not easily altered toileting." There was no specific interventions alidation" prior to the g Haloperidal as an						
	was screaming, of and disruptive. It is a saily altered by was no indication interventions we intervention and intervention are receiving Halope Particles and Particles August 2011 ind (8:30 P.M.), "Residual and the sail of the sail o	A.M.: "Resident #16 causing excessive noise The behavior was not 1:1 or toileting." There n of what specific re used for the "1:1 or to the resident eridal as an intervention. s notes for the month of icated on 8/6/11 at 2030 s [Resident] agitated this redirected. Combative						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (		PLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LDING	00	COMPLETED		
155376		B. WIN			09/16/20	011		
					ADDRESS, CITY, STATE, ZIP CODE	l .		
NAME OF PROVIDER OR SUPPLIER				803 S	HAMILTON STREET			
	AN REHABILITATIO	N AND HEALTHCARE CENTER		SHERIE	DAN, IN46069			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE	
	[with] staff." The							
	documentation re							
		re used to try and redirect						
	the resident. The	ere were no nursing notes						
	for 8/15/11, 8/17	/11 or 8/19/11.						
	A Care Plan for b	pehaviors, dated 8/10/10						
	and updated quar	terly, indicated Resident						
		of visual hallucinations,						
	1	· · · · · · · · · · · · · · · · · · ·						
	paranoid delusions, was resistive to care, wandered and was verbally abusive.  Approaches included, but were not							
	* *							
	limited to, allow for safe wandering, explain task, talk with resident throughout care, and explain need for care to be given.  A computer "Care Tracker" printout, received from the Assistant Director of							
	Nursing on 9/16/	11 at 9:15 A.M., listed						
	the following interventions for Mood and Behavior:  "When resident upset try to take to a quiet area, sit resident in recliner and stroke hair to encourage her to relax; give resident chocolate to help distract her; and resident enjoys music, especially country music."  In an interview on 9/16/11 at 9:15 A.M.,							
	the Assistant Director of Nurses indicated							
		ns were available to all						
	staff using the "Care Tracker" system, and							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155376			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING 00			09/16/2011		
100070			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1 00/10/2	
NAME OF PROVIDER OR SUPPLIER				1	HAMILTON STREET		
SHERIDAN REHABILITATION AND HEALTHCARE CENTER			1	1	DAN, IN46069		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
IAG		opped up" on the terminal		IAG			DATE
		the nursing staff person					
	using the system	<b>C</b> 1					
	dsing the system	to respond.					
	During an intervi	iew on 9/16/11 at 9:15					
	~	ant Director of Nursing					
	· · · · · · · · · · · · · · · · · · ·	vas no documentation of					
	which intervention	ons were used to redirect					
	l '	which interventions					
	worked most often during outbreaks of behaviors. The "Care Tracker" printout						
	was only a summary of dates and times an intervention was used, but did not capture documentation of which interventions from the list that were used.  B.1. The clinical record for Resident #14						
	was reviewed on	9/14/11 at 2:00 P.M.					
	Diagnoses included, but were not limited						
	_	al disease, renal dialysis,					
	depressive disorder, and non-insulin dependent diabetes.  Physician's orders for 9/2011 included, but were not limited to, "1500 milliliters [ml] fluid restriction - 340 ml each meal,						
	120 ml each med						
	120 mi cacii meu	noution pass					
	In an interview o	n 9/15/11 at 12:45 P.M.,					
		ted Resident #14 was on					
		of 1500 ml. daily. She					
		d not keep track of the					
		ant consumed by the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CC	INSTRUCTION	I .	(X3) DATE SURVEY	
		155376	A. BUI	LDING	00	COMPLETED 09/16/2011		
155576			B. WIN			09/10/2	011	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
SHERIDAN REHABILITATION AND HEALTHCARE CENTER				1	HAMILTON STREET DAN, IN46069			
					7/114, 114-10000		(V.5)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	DATE	
		our period. The nurse						
		dent's dialysis agency						
		daily fluid intake "by						
	1 ^	it was taken off [fluid						
		hemodialysis]" on						
	ı	P.N. #6 indicated there						
	•	Resident #14's actual						
	fluid intake.							
	In an interview on 9/15/11 at 1:20 P.M., the resident and his wife indicated they							
	did not know how his fluid restriction							
	worked in the facility. The resident was							
	not asked what fluids he preferred to							
	drink, or how he would like his fluids							
	divided throughout the day. For this							
	reason, Resident #14 indicated he never							
	· ·	ks on his meal trays						
		he should not be						
		cause of his kidney						
	disease. Resident #14's wife also indicated she did not realize his fluids were divided for meal trays and medication passes.  On 9/15/11 at 2:20 P.M., a document titled "Nutrition Services Manual:							
	Nutrition Practic	e: Fluid Maintenance"						
	with review date	of 6/09 was provided by						
	the Assistant Dire	-						
	[ADoN]. The do	ocument included, but						
	was not limited to	o the following:						
	"The Nutrition S	ervices and Nursing Staff						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING  B. WING			COMPLETED 09/16/2011			
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  803 S HAMILTON STREET					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	are responsible for and recording of	or managing the delivery						